



National Service & Legislative Headquarters  
807 Maine Avenue, S.W.  
Washington, D.C. 20024-2410  
Phone (202) 554-3501  
Fax (202) 554-3581  
[www.dav.org](http://www.dav.org)

**STATEMENT OF  
JOY ILEM  
DAV NATIONAL LEGISLATIVE DIRECTOR  
ON BEHALF OF THE CO-AUTHORS OF  
THE INDEPENDENT BUDGET  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
JUNE 22, 2017**

Chairman Wenstrup, Ranking Member Brownley and Members of the Subcommittee:

On behalf of DAV (Disabled American Veterans) and as one of the co-authors of the *Independent Budget*, along with Paralyzed Veterans of America and Veterans of Foreign Wars of the United States, I am pleased to present our views on the resource needs of the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) for fiscal year (FY) 2018 and advance appropriations for FY 2019. I associate my remarks with the statements and recommendations provided by our *Independent Budget* partners for VHA medical care accounts, construction accounts and the National Cemetery Administration. I will concentrate my remarks on the budgetary needs of a few of VA's most critical programs for ill and injured veterans—mental health care, suicide prevention, homelessness, women veterans and caregivers.

While we appreciate the increases recommended in the President's budget for veterans health care in FY 2018, we are concerned the budget will not meet increasing demand for care and allow VA to meet its goals of providing timely, high quality care to veterans both in VA and the community. We applaud Secretary Shulkin for his leadership and efforts over the past few years to improve veterans' access to care and timeliness of services with a focus on creating a strong management team, increasing operational efficiency, streamlining and replacing outdated business processes, modernizing the veterans benefits system, health infrastructure and information technology (IT) system to include a new scheduling package and electronic health records system. The Secretary has also set a number of priorities to include: greater choice for veterans; building a high performing network of care to enhance VA services while optimizing community care options, expanding mental health services to veterans in crisis with less than honorable discharges, and an increased focus on suicide prevention efforts to eliminate veteran suicide. While we welcome increased funding to improve care and services for ill and injured veterans we want there to be an honest assessment and discussion about what the real costs are for accomplishing all of these important goals.

DAV, along with our *Independent Budget* partners note two proposals contained in the Administration's budget that we strongly oppose. One, a provision that would scale back VA's

Individual Employability (IU) benefit for thousands of veterans that are unable to maintain gainful employment as a result of their service-connected disability. Specifically, this proposal would terminate existing IU ratings for veterans, along with associated ancillary benefits, when they reach the minimum retirement age for Social Security purposes, currently 62, as well as cut off IU benefits for any veteran already in receipt of Social Security retirement benefits. This proposal is simply an unjust penalty and would place an undue financial hardship on all service-disabled veterans in receipt of IU and their families.

The second proposal would round down cost-of-living adjustments (COLAs) for disability compensation, Dependency and Indemnity Compensation (DIC) and some other benefits for the next 10 years. Veterans and their survivors rely on their disability compensation for essential purchases such as food, transportation, rent and utilities. This provision would unfairly target disabled veterans, their dependents and survivors to save the government money and offset the cost of other federal programs. All totaled, VA estimates this proposed COLA round down would cost beneficiaries close to \$2.7 billion over the next 10 years. We are pleased that the Secretary acknowledged the negative impact the IU proposal would have on service-disabled veterans and indicated he was interested in finding another funding source to pay for Choice. We ask the Subcommittee to reject these proposals and reconsider the resources necessary for VA to meet the needs of our nation's veterans.

### **Mental Health Care**

An independent study found that most of VA's mental health providers were working at peak capacity and despite VA's concerted effort to hire more mental health clinicians, shortages still exist at some locations. Without sufficient resources, the *Independent Budget* veterans service organizations (IBVSOs) are concerned that this could potentially affect veterans' access to timely and appropriate care, particularly for specialized mental health services.

Demand for VA mental health care services has grown significantly as Vietnam veterans age and our more recent war fighters return from combat deployments (often multiple deployments) and leave military service. Experts estimate that about 20 percent of our newest generation of war veterans are affected by post-traumatic stress disorder (PTSD). Researchers note that veterans using VA care from Operations Iraqi Freedom, Enduring Freedom and New Dawn (OIF/OEF/OND) have a high burden of post-deployment mental health challenges (56 percent have a mental health diagnosis). Subgroups within this population, such as service-connected women veterans, also have an even higher prevalence of mental health needs. While VA has made progress and focused its efforts on outreach, decreasing stigma and improving access to a wide variety of mental health services, there continue to be unmet needs. Many of our most vulnerable veterans have risk factors associated with or exacerbated by their military service that lead to family disintegration, legal issues, unemployment, homelessness and unfortunately, in some cases, suicide.

Despite the challenges, research indicates that veterans who are engaged in VA care and treatment programs are less likely to take their lives. Likewise, veterans with serious mental illnesses using VA health care have longer life expectancies than other Americans with such conditions. Integration of mental health services into VA primary care settings and the

development and use of evidence-based practices to treat disorders such as PTSD linked to combat and sexual trauma have proven effective. We are pleased that VA, as part of its suicide prevention efforts, is also beginning to use analytic predictive models (VA REACH VET initiative) to better identify at-risk veterans. While problems, including the timeliness of care and sufficient staffing levels remain at certain locations, we believe veterans with serious mental illness, PTSD (associated with combat or sexual trauma), or post-deployment mental health challenges are best served by VA's highly specialized and comprehensive mental health care model.

VA's primary care teams with integrated behavioral health services routinely identify and refer veterans for advanced screening for such commonly diagnosed conditions as depression, anxiety, and substance use disorders. We commend VA for ensuring mental health is considered an important part of a veteran's overall health—but this new model of care has increased the need for mental health services among thousands of VA patients who have not previously used these services. VA will need to continue to attract, hire and train a sufficient number of mental health professionals, including family and marital counselors and community partners in some locations to meet rising demand and provide timely and individualized care. VA must also continue its efforts to help family members coach struggling veterans into care and keep them engaged in treatment. VA must also focus on meeting the diverse needs of its veteran population to include elderly veterans, Vietnam veterans, and women veterans.

PTSD often co-occurs with other mental health issues including substance use disorders, depression, and traumatic brain injury. Veterans with “dual diagnoses” are often among the most difficult to treat and require intensive care and case-management. VA must continue to research more effective treatments to address these complex patients with comorbid conditions. Likewise, clinicians must have the ability to schedule and carry out more resource intensive, evidence-based treatments for veterans who need it. VA clinicians are beginning to understand the value of peer specialists as these professionals are often able to engage isolated veterans because of their shared military experience, and better assist veterans with patient education and navigating VA's complex health care system.

VA must have sufficient resources to treat case-intensive veterans with serious mental illness, employ more peer specialists, properly staff the veterans crisis line, increase outreach and focus on shared prevention efforts, and develop programs that meet the unique needs of women veterans who are at high risk for homelessness and suicide.

There must be continued oversight by the Subcommittee to ensure that VA has the resources necessary to provide timely and individualized mental health care to a diverse veteran population. Sufficient resources are necessary to meet increased demand for specialized mental health care services for PTSD, substance use disorder, serious mental illness or for veterans who have experienced military sexual trauma. VA must also have sufficient resources to properly staff the veterans crisis line, improve suicide prevention efforts and develop programs that meet the unique needs of women veterans who are at high risk for homelessness and suicide.

We urge the Subcommittee to ensure VA mental health programs continue to receive adjustments commensurate with increased workloads and continue to monitor VA's ability to

fully implement newly authorized services and programs, such as those contained in Public Law 114-2, the Clay Hunt Suicide Prevention for American Veterans (SAV) Act.

Another issue that will require the Subcommittee's oversight is the proposal to provide veterans with other than honorable discharges access to urgent health and mental health services. We commend Secretary Shulkin for taking steps to address the needs of this population (an estimated 500,000 veterans). We know that many of these individuals have PTSD, experienced military sexual trauma or have undiagnosed mental health issues or a mild traumatic brain injury that may have contributed to behavior that led to their less favorably characterized administrative discharges.

While we acknowledge the Secretary's assertion that he does not require increased funding to address the potential increase in workload, we believe the impact on access to mental health care could be significant and may require hiring of additional providers as well as clinical and Vet Center space to accommodate increased demand. We recommend that VA identify the full estimated cost of implementing this decision and request that Congress provide additional funds if necessary. The IBVSOs believe these veterans need and should receive this critical care, especially veterans who may have sustained a brain injury during military service or suffering from a mental health condition that went undiagnosed or untreated.

### **Veterans' Homelessness**

Unemployment, homelessness and suicide are often the consequences of a failed mental health safety net. Since 2010, based on intensely focused resources and efforts, VA and its partner agencies have decreased the numbers of veterans who are homeless by nearly 50 percent.

In the FY 2018 budget plan, the Administration requested less funding for VA's psychiatric rehabilitation and homeless veteran domiciliary beds and a significant cut to funding for these beds in FY 2019. These cuts will undermine veterans' recovery. It is unrealistic to expect veterans who are homeless or in unstable housing to achieve difficult treatment goals such as achieving sobriety (or even reducing dependency upon substances) or attending to basic hygiene, independent living and vocational skills in order to successfully reintegrate into their communities. Psychiatric rehabilitation and domiciliary beds were designed as a less intensive and more cost-effective alternative which still give veterans a stable environment from which to launch recovery. Many of the veterans using such programs also have significant medical and mental health issues to address after living on the street. Without access to stable, supervised lodging and adequate nutrition and rest, these vulnerable veterans' chances to recover from years of addiction and/or significant chronic mental illness including psychoses and severe PTSD are severely jeopardized.

Unfortunately, the progress made through collaborations between VA, other federal agencies, states and community partners appear imperiled by the current budget proposal. Proposed cuts in programs will impact the ability for homeless veterans to receive comprehensive services. While these proposals are outside of the House Veterans' Affairs Committee's jurisdiction in agencies such as HUD, the Interagency Council on Homelessness, the Legal Services Corporation, the Small Business Administration and Medicaid—they will impact this population. VA has

invested a significant amount of resources to reduce the number of homeless veterans and we are very concerned the potential cuts to these important programs could undermine VA's progress to end homelessness among this population. VA's ability to work with other federal, state, and local agencies is critical to providing a comprehensive set of services to veterans who are homeless—from rehabilitation to reintegration into society with a goal of good health, recovery from mental illness or addiction and long-term stable employment and housing.

### **Women Veterans**

The delivery of care for women veterans has been a special challenge for VHA. While the number of women serving in the military continues to grow as does the number of women coming to VA for care, women still comprise a relatively small portion (about 11 percent) of VA's patient population. For these reasons, it has often been difficult for VA, especially outside of urban population centers, to provide high-quality comprehensive services in-house to women. Today, women serving in combat theaters are exposed to serious injury or death like their male counterparts. This new reality requires a focus on meeting the unique needs of an increasing number of women veterans in a health care system historically devoted to the treatment of men.

Learning how to care for wounded women veterans, half of whom are of childbearing age, and their particular health issues and transition and rehabilitation needs includes learning how to best meet their needs for prosthetic and assistive devices. The IBVSOs recognize and commend the VA's efforts to enhance the care of female veterans in regard to technology, research, training, repair, and replacement of prosthetic appliances through the establishment of a women's prosthetic working group. The working group's mission was to eliminate barriers to prosthetic care experienced by women veterans and change the culture and perception of women veterans through education and information dissemination.

The IBVSOs recommend the Medical Services appropriation for FY 2018 be supplemented with \$110 million designated for women's health care programs. These funds would be used to help the VHA deal with the continuing growth in women veterans coming to VA for care, including coverage for gynecological, prenatal, and obstetrical care, other gender-specific services, and for expansion and repair of facilities to improve privacy and safety for women receiving care. VA must also be able to continue its important research on the health impacts of wartime service on women veterans to better address the high rates of homelessness, suicide and unique transition challenges among this population.

Additional funds would also aid the Department in its efforts to transform the culture of the system to ensure women veterans are provided equal benefits and health care services, have access to comprehensive care in a safe, private and comfortable setting and are recognized for their service and made to feel welcome at VA. Funds are necessary to address identified gaps in current programs and services, particularly post-deployment readjustment services for women veterans.

Like all veterans, women veterans deserve the opportunity to receive care in VA with access to its highly specialized transition and rehabilitation services, veteran-focused research and care and psycho-social wrap-around supportive services. This is especially critical for service-connected

women veterans, women veterans with wartime service and veterans who have experienced sexual trauma.

### **Caregiver Support**

A final issue we ask the Subcommittee to consider championing is fixing the inequity of the current law supporting seriously disabled veterans' caregivers. The IBVSOs have worked diligently for many years as a part of a larger coalition of veterans organizations that promoted the advent of family caregiver support services for severely injured and ill veterans. Congress enacted Public Law 111-163, the *Caregivers and Veterans Omnibus Health Services Act of 2010*. However, that law limited services and supports to family caregivers of veterans who were injured or became severely ill in military service only on or after September 11, 2001. That omission left thousands of veterans' families without the level of caregiver support and services they needed because those veterans' health challenges or war injuries occurred before that effective date.

Legislation has been introduced in both Chambers that would address this inequity and improve the lives of tens of thousands of veteran families. Not only is it the right thing to do for seriously ill and injured veterans, it will save the federal government a significant amount of resources that otherwise would need to be spent to provide more costly institutional care solutions for these veterans. We ask that resources be included in the budget to resolve this issue.

In closing, we ask the Subcommittee to consider, as the budget process moves forward, that this is very critical time for VA. The new Administration has pledged support for our nation's veterans and Secretary Shulkin has committed to carry out that promise by creating a system that is worthy of their service and sacrifices. As VA moves forward to rebuild trust with veterans, make needed reforms and carry out modernization plans to strengthen and improve the VA, for the benefit of those who served, it is critical it has the resources and support it needs to be successful.

Mr. Chairman, thank you for the opportunity to share the *Independent Budget* recommendations at this hearing today. I am prepared to answer any questions you or other members of the Subcommittee may have.